STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Gardens	1438 County Road C East Maplewood, MN 55109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on observation, interview and document review the facility failed to ensure care planned interventions were followed during transfer for 1 of 3 residents (R1) reviewed for accidents when staff failed to use a transfer belt. This resulted in actual harm for R1 who fell during a staff assisted transfer and sustained a subarachnoid hemorrhage. The deficient practice was corrected prior to the start of the survey therefore, was issued at past noncompliance. Findings include: R1's Resident Face Sheet indicated R 1 was readmitted to the facility on [DATE]. The face sheet identified diagnosis that included vascular dementia, cerebral infarction with left sided weakness, anemia and heart failure. R1's admission Minimum Data Set, dated dated dated [DATE], identified intact cognition and indicated he required partial to moderate assistance for transfers. R1's care plan dated 9/3/24, indicated impaired self ability with transfers and ambulation. The care plan directed staff to provide contact guard assistance with transfers. The care plan further identified a risk for falls and directed staff to follow the toileting and repositioning schedule. R1's nursing assistant (NA) care guide, undated, directed staff to provide contact guard assitance for transfers using a two wheeled walker. R1's Physician Order Report dated 9/1/24 through 9/20/24, identified the use of Eliquis (anticoagulant medication used to treat and prevent blood clots),5 milligrams daily. A facility Event Report dated 9/11/24, indicated R1 fell in his room at 7:35 p.m. The report identified an injury on the left side of R1's face above the eyebrows and bruising on lower eyelid. The report further indicated at the time of the fall, R1 was with a nursing assistant (NA) and getting ready to transfer to the bathroom. R1's Progress Notes identified the following: 9/11/24, R1 was about to be transferred to the wheelchair for a shower when he fell and hit his head. Swelling and bleeding was noted on the left anterior side of his forehead and bruising on right side of lower eyelid. R1 was sent to the hospital. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Gardens	1438 County Road C East Maplewood, MN 55109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	9/18/24, R1 readmitted to the facility with diagnosis of fall with subarachnoid hemorrhage. R1 was alert to himself and redirected as to time, situation and others. R1 was noted to be repeating everything that staff asked him and complained of a headache and pain. R1 had a large dry scabbed laceration across the left side of his forehead and temple area, with dark bruising and swelling under both eyes and marked swelling over left eyebrow and eyelid. R1's hospital History and Physical (H and P) dated 9/12/24, indicated R1 presented for a trauma consult after a ground level fall with head strike which resulted in the following injuries: Subarachnoid Hemorrhage (BIG3). (BIG 3 injuries are managed with admission, a neurosurgery consultation and at least one scheduled repeat head CT (computed tomography). Emergency Department (ED) workup was significant for the following injuries: Small acute subarachnoid hemorrhage, left front scalp hematoma and repaired laceration. R1's Physical Therapy Treatment Encounter Notes indicated the following: 9/11/24, Precautions included confusion and fall risk. Sit to stand with minimum assitance of one. Ambulation with rolling walker and contact guard assitance 100 feet times two. Response to session: tolerated treatment well. 9/19/24, Precautions included confusion and fall risk. R1 ambulated five feet laterally, forward and retro with minimal assitance. Cueing on sequencing of walker and taking steps in proper direction. Response to session interventions: Decreased awareness, ability to follow cues, often repeats what is said without performing the action. During observation and interview on 9/19/24 at 10:27 a.m. R1 was laying in bed. R1 had black bruises under both eyes. Across both eyes was bruising in varying shades of red and purple. R1 also had a bump above his left eye approximately the size of a golf ball. R1 stated he had a fall of some kind but did not remember much about the fall. R1 said he had not been moving around much since he returned from the hospital. When asked if he felt safe transferring with staff, R1 replied, sort of. During interview on 9/19/24 at 12:49 p.m. NA-A stated she had been taking care of R1 since he admitted to the facility. NA-A stated the day of the fall she placed the wheelchair next to the bed to transfer for a shower and said R1's legs gave out. NA-A stated she had not used a gait belt because she knew R1 could grab onto the chair. NA-A said when R1 fell , he was on his knees and she grabbed him around his waist and R1 hit his head on the floor. NA-A stated she was aware the facility transfer policy directed staff to use a transfer belt and stated R1 was supposed to have a gait belt on when transferring. NA-A further stated she was re-educated on the use of the transfer belts after the incident occurred. During interview on 9/19/24 at 12:59 p.m., the director of nursing (DON) stated when R1 fell on [DATE], she called NA-A the next morning and asked specifically if she had used a transfer belt and indicated staff were educated to always use a transfer belt unless otherwise indicated by therapy. The DON said NA-A told her she had not used a transfer belt because R1 had been transferring well. The DON stated after the incident the facility had educated all staff and had been performing audits to ensure the care plan was followed. During interview on 9/19/24 at 1:15 p.m., the certified nurse practitioner reviewed R1's hospital H and P and stated there had been no indication R1 had suffered a stroke at the time of the fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Gardens	1438 County Road C East Maplewood, MN 55109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During interview on 9/19/24 at 1:20 p.m., occupational therapist (OT)-A said prior to R1's fall he required assistance from one staff in his room using a walker. OT-A clarified, assist of one meant he required some physical assistance and the use of a gait belt and said contact guard assistance would also require the use of a gait belt. During interview on 9/19/24 at approximately 1:45 p.m. physical therapist (PT)-A stated he had worked with R1 quite a bit. PT-A stated he had seen changes since the fall and said R1 was having difficulty processing and following cues and said R1 had been repeating everything he said that morning. PT-A said prior to the fall R1 had been able to consistently follow directions. PT-A stated R1 seemed weaker and said he could physically transfer but the processing, he doesn't get it. Facility policy Transfer/Ambulation Assist Using Gait/Transfer Belt dated 3/25/24, indicated transfer belts will be used for all residents who require physical support for mobility or safety in transfers. Prior to the start of the survey the facility initiated education related to the transfer belt policy and use of transfer belts. Further the facility initiated compliance audits to ensure staff were following the plan of care. The education and audits were verified through interview and document review.